



**Counselling and Care Centre** (UEN: S75SS0014F)

536 Upper Cross Street #05-241 Hong Lim Complex Singapore 050536 Tel 65366366

Fax 65366356

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**Individual Consultation Request Form**

<b>Personal details</b>		
Name	Gender: Male/Female	Age:
Designation		
Organisation (if applicable)		
No. of years in social services	No. of years of counselling experience	
Education and Training Background		
Brief description of your current clientele / population		
What prompted your request for consultation at this point?		
Consultation goals/objectives		
<i>(Important note: We do not provide individual supervision or internship for fulfilment of requirements for completion of any formal training or qualified courses in counselling, social work or psychology etc.)</i>		
<b>Request specification</b>		
Frequency <i>(Note: No consultation for the months of June and December)</i> <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Others (please specify): _____		
Number of hours per session <input type="checkbox"/> 1 hour <input type="checkbox"/> 1.5 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> Others: _____		
Preferred day of the month and time (with the exception of Wednesday afternoons) <i>(E.g. 1<sup>st</sup> Monday of each month, 9am-12pm; please indicate at least 2 choices)</i>		
Choice 1: _____		
Choice 2: _____		
Choice 3: _____		

Preferred mode (you may tick more than one):

- Live/ video/audio recorded consultation (minimum 1.5hrs per session)  
 Case consultation  
 Others (please specify): \_\_\_\_\_

Duration of consultation

- 1 year  
 2 years  
 3 years [maximum]  
 Others : \_\_\_\_\_

*(Please note that minimum contract period is 6 sessions within a year to a maximum of 20 sessions that should be evenly spaced out and completed in a period of 2 years. Contract with the same consultant is renewable up to 2 consecutive years.)*

Preferred Date of Commencement: \_\_\_\_\_

*(Please give **at least 2 months** from your date of submission of this request form.)*

Please state any other requests you may have:

**Billing**

Please tick:

- Self paying  
 Agency/Organisation sponsored

Submitted by: (Name) \_\_\_\_\_

Please state designation and organisation if above name is different from the applicant: \_\_\_\_\_

Contact number: \_\_\_\_\_ Email: \_\_\_\_\_

Date of submission: \_\_\_\_\_

*Note: Please submit this form to [training@counsel.org.sg](mailto:training@counsel.org.sg)*

**For Official Use**

1<sup>st</sup> session date:

2<sup>nd</sup> session date:

*Please book subsequent dates upon every visit.*